



TEXAS DEPARTMENT OF STATE HEALTH SERVICES

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COMMISSIONER

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EMS PROVIDER
REPORT OF EXPENDITURES FY __ (EMS/COUNTY -- 911/1131/3588 Funds)
(A report is needed for each provider)

COUNTY of LICENSURE: _____

Counties of Operation: _____

Name of EMS Provider: _____

Name of EMS Administrator (Print): _____

Re: Utilization of Funds Received from the Emergency Medical Services (EMS) Trauma Care System Account (911 Funds) and Emergency Medical Services, Trauma Facilities, and Trauma Care Systems Fund (1131 Funds) and Designated Trauma Facilities and Emergency Medical Services Account (3588 Funds)

Total Amount of Allocation this Provider Received: \$ _____

Purchases/expenditures during period _____ - _____:
Contract Start Date Contract End Date

“Contractor shall submit a list of each provider’s expenditures with **proof of payment. Examples of acceptable proof of payment include receipts showing paid in full, cancelled checks, invoices with \$0 balance, or a handwritten receipt must be noted as to how it was paid.”**

Supplies: Item: _____ Cost: \$ _____
Item: _____ Cost: \$ _____
Item: _____ Cost: \$ _____
Item: _____ Cost: \$ _____

Education & Training: Course: _____
Persons Trained: _____ Date: _____
Cost: \$ _____

Equipment: Type: _____ Cost: \$ _____
Type: _____ Cost: \$ _____
Type: _____ Cost: \$ _____

Vehicles: Type: _____ Cost: \$ _____
 Type: _____ Cost: \$ _____

Communications Equipment:
 Type: _____ Cost: \$ _____
 Type: _____ Cost: \$ _____

Other Operational Expenditures: _____

Anticipated Expenditures through August 31, _____, if any: _____

Total Cost: \$ _____

Anticipated Expenditures for any funds not expended by August 31. (Not required if entire contract amount is expended by August 31): _____

Total Cost: \$ _____

Name of person completing report (Print): _____
Title: _____ Phone: _____

RAC/County Authorized Signature: _____ Title: _____
Name (Print): _____ Date: _____

*Please attach additional page if necessary.